PREADMISSION SCREENING AND RESIDENT REVIEW/ MENTAL ILLNESS (PASRR/MI) LEVEL II EVALUATION DOCUMENT

I D E N T I F I C A T I O N

DMH-ID: LEVEL I:__ / __ / ____

REASON ASSESSMENT WAS NOT COMPLETED: _____
REASON: _____

1) DMH-ID: _____- _____

2) MEDI-CAL-ID: ___- _____-_____- _____ N/A___

3) SSN: ___ - __ - ____ N/A ____

4) Name - Last: _____ First: _____ Initial:_____

5) Date Of Birth: ___/_____/ _____ Age: _____ 6) Gender: _____

7)Language Used to Administer This Evaluation:_____

a)Was Individual Fluent in This Language?: Y____ N____

b)Did Individual Participate in This Language?: Y____ N_____

c)If "N", Name of Interpreter: Last:_____ First:_____

d)Interpreter's Relationship to Individual:_____

e)Individual's Language_____

8) a) Facility Name: _____ b)Facility Number:_____

9) Facility County Code:

10) Date Of Current NF Admission: __ / __ / ____ 11) Months/Current NF:

12) Legal Class Code: __

13) Level 1: __ / __ / ____ 14) Level 2: __ / __ / ____ 15) PAS RR ER SS RRR

16) Date of Last MDS: _ / __ / __
Other: _____ Date:_____

17) Admitted From: _____
Other: _____ (MDS Section AB.2)

18) Education: _____ (MDS Section AB.7)

19) Marital Status: : _____ (MDS Section A.5)

20) Conservator Name: _____ N/A ____

21) Conservator Address: Street Name: _____

City: _____ State: _____ Zip: _____

22) Conservator Phone Number(with area code):_____

23) Participants: ___Individual ____Family member _____Friend
___Conservator ____Other_____

P S Y C H O S O C I A L A S S E S S M E N T

24) INDIVIDUAL GOALS: Check all that describe the individual's goals.

a)Housing/Living Goal:(check all that describe the individual's goals)
i.__Live alone ii.__Live with roommate(s) iii.__Live with family
iv.__Group home v.__Nursing facility vii.__Other:_____

b)Finance/Vocation Goal:(check all that describe the individual's goals)
i.__Work in competitive FT/PT ii.__Volunteer Work iii.__Attend school/class iv.__Not interested in work or school v.__Other:_____

c)Relationships/Family:(check all that describe the individual's goals)
i.__Improve contacts ii.__Increase contacts iii.__All okay/No Family
iv.__Other:_____

d)Relationships/Peers:(check all that describe the individual's goals)
i.__More contacts with friends ii.__Improve quality of contacts with friends iii.__Make new friends iv.__All okay v.__Other:_____

e)Health/Physical:(check all that describe the individual's goals)
i.__Lose weight ii.__Gain weight iii.__Reduce pain/discomfort
iv.__Exercise more v.__Sleep better vi.__Improve mobility vii.__Improve thinking/memory viii.__Improve vision ix.__Better hearing x.__No Goal
xi.__Other:_____

f)Health/Mental:(check all that describe the individual's goals)
i.__Feel happier ii.__Reduce anxiety iii.__Reduce anger
iv.__Think more clearly v.__Reduce drug/alcohol use
vi.__Stop hallucinations vii.__Other:_____

25) INDIVIDUAL'S REPORT OF PERFORMANCE OF BASIC LIVING SKILLS

Level of Assistance Ratings: None=I can do it on my own; Explain=If someone explains what I must do; Physical=If someone physically helps me perform parts of the skill; All=Someone else must do it all for me.

a) Area: FRIENDS

In the past 3 months, DID YOU	Answer		If NO, assistance client needs to perform the skill			
Question	Y	N	None	Explain	Physical	All
1 have close friends where you lived; someone you spent time with, talked to, and did things with, more than just said hello?.....	__	__	___	___	___	N/A
2 have close friends in other places; someone you spent time with, talked to, and did things with?.....	__	__	___	___	___	N/A
3 Do you want to make it a goal to improve your friendships and make new friends?.....	__	__				

4 Comments/Observations/Clarifications:_____

_____

b) Area: PERSONAL HYGIENE

In the past 2 days, DID YOU	Answer		If NO, assistance client needs to perform the skill			
Question	Y	N	None	Explain	Physical	All
1 take a shower or bath on your own?....	__	__	___	___	___	___
2 brush your teeth on your own?.....	__	__	___	___	___	___
3 brush or comb your hair on your own?..	__	__	___	___	___	___
4 choose your clothes on your own?.	__	__	___	___	___	___
5 dress yourself on your own?.....	__	__	___	___	___	___
6 Do you want to make it a goal to improve your personal hygiene?.....	__	__				

7 Comments/Observations/Clarifications: _____

_____

c) Area: CARE OF PERSONAL POSSESSIONS

(Time frame is listed in each question)	Answer		If NO, assistance client needs to perform the skill			
Question	Y	N	None	Explain	Physical	All
1 In the last week, did you wash your clothes on your own?.....	__	__	___	___	___	___
2 In the last 2 days, did you clean your room on your own?.....	__	__	___	___	___	___
3 In the last 2 days, did you make your bed on your own?.....	__	__	___	___	___	___
4 In the last 2 days, did you put away your clothes on your own?.....	__	__	___	___	___	___
5 In the past 3 months, did you keep your possessions and not give them away?.....	__	__	___	___	N/A	N/A
6 Do you want to make it a goal to improve how you take care of your things?.....	__	__				

7 Comments/Observations/Clarifications: _____

_____

P S Y C H I A T R I C H I S T O R Y

26) a. Drug Abuse: _
b. Alcohol Abuse: _

0 = Unknown 1 = None 2 = Mild
3 = Moderate 4 = Severe

27) Age at onset of mental illness __

28) Primary living situation during past year
__ State Hospital _ Nursing Facility
__ Board and Care _ With Family
__ Independent Living _ Other (specify) _____

29) No. of Psychiatric hospitalizations in past two years ___

30) Behavioral / Management Problems No evidence --- Number of Days of: 0-14 15-30 31-60 61-90

a. No. of PRN psychiatric medications in past..... ☐	__	__	__	__	__
b. No. of times refused medication in past..... ☐	__	__	__	__	__
c. No. of times abused alcohol until drunk in past..... ☐	__	__	__	__	__
d. No. of times used street drugs in past..... ☐	__	__	__	__	__
e. No. of times tried to go AWOL in past ☐	__	__	__	__	__
f. No. of times damaged others' property in past ☐	__	__	__	__	__
g. No. of times smoked in a hazardous manner in past ☐	__	__	__	__	__
h. No. of fire setting incidents in past ☐	__	__	__	__	__
i. No. of times disrobed in public in past ☐	__	__	__	__	__
j. No. of times engaged in sexual activity that violated the rights of others in past ☐	__	__	__	__	__
k. No. of times others' property stolen in past ☐	__	__	__	__	__
l. No. of times verbally assaulted others (yell, scream, swear, call names) in past ☐	__	__	__	__	__
m. No. of times physically hurt others (hit, pinch, shove, trip) in past ☐	__	__	__	__	__
n. No. of times tried to hurt self in past ☐	__	__	__	__	__
o. Other:					

PSYCHIATRIC MEDICATIONS

31) Current psychiatric medications:

	Name	Code	Dose (MG)	PRN y/n?	Freq	Daily Total	Purpose cd	Purpose desc	Response cd	Response desc
a.	_____		____	____	_____	___	___	_____	___	_____
b.	_____		____	____	_____	___	___	_____	___	_____
c.	_____		____	____	_____	___	___	_____	___	_____
d.	_____		____	____	_____	___	___	_____	___	_____
e.	_____		____	____	_____	___	___	_____	___	_____
f.	_____		____	____	_____	___	___	_____	___	_____

g. Long acting psychiatric medication: _____ (code) (dose): ____

Times per: __ week __ 2 weeks __ 3 weeks __ month

32) SIDE EFFECTS OF MEDICATION Y = Yes N = No NR = No Response

Ask client: "In the last 3 months, have meds caused you problems like":

Side Effect	Y	N	NR	Side Effect	Y	N	NR	Side Effect	Y	N	NR
thirsty.....	_	_	_	tired, sluggish.	_	_	_	dry mouth	_	_	_
nervous, jittery	_	_	_	rigid muscles...	_	_	_	dizziness	_	_	_
blurred vision.	_	_	_	Diarrhea.....	_	_	_	jaw movements	_	_	_
constipation...	_	_	_	tremors/shaking.	_	_	_	sunburn	_	_	_
drooling.....	_	_	_	nausea/vomiting	_	_	_	weight gain/loss	_	_	_
headaches.....	_	_	_	impotence(males)	_	_	_	appetite change	_	_	_

33) Comments/Observations/Clarifications (optional)

_____

_____

34) SYMPTOMS (Individual's Report)

In the past 3 months, have you experienced	Y	N	NR	Answer (If present, describe, including frequency)
a. Thought disorder/Delusions?	__	__	__	EXPLAIN_____
b. Hallucinations?	__	__	__	EXPLAIN_____
c. Anxiety?	__	__	__	EXPLAIN_____
d. Depression?	__	__	__	EXPLAIN_____
e. Suicidal thoughts?	__	__	__	EXPLAIN_____

35) Problem Behaviors (Individual's Report)

In the past 3 months, have you:	Y	N	NR	Answer (If yes, describe, including frequency)
a. used street drugs?	__	__	__	EXPLAIN_____
b. abused alcohol so that you were drunk at least once per month?	__	__	__	EXPLAIN_____
c. physically hurt others (hit, pinch, shove, trip)?	__	__	__	EXPLAIN_____
d. verbally assaulted others (yell, scream, swear, call names)?	__	__	__	EXPLAIN_____
e. tried to hurt yourself?	__	__	__	EXPLAIN_____
f. engaged in sexual activity that violated the rights of others?	__	__	__	EXPLAIN_____
g. smoked in a hazardous manner (in bed, flick ashes in trash, etc)?	__	__	__	EXPLAIN_____
h. damaged others' property?	__	__	__	EXPLAIN_____
i. disrobed in public?	__	__	__	EXPLAIN_____
j. stolen others' property?	__	__	__	EXPLAIN_____
k. tried to go AWOL from a facility?	__	__	__	EXPLAIN_____

P H Y S I C A L H E A L T H H I S T O R Y

36) Current physical health problems: (MDS Sections G,H,I,J)

a.) _ None

b.) Infectious/Parasitic Diseases (MDS Section I)

1. _ None
2. _ Antibiotic resistant infection
3. _ Clostridium Difficile
4. _ Conjunctivitis
5. _ HIV infection
6. _ Pneumonia
7. _ Respiratory infection
8. _ Septicemia
9. _ Sexually Transmitted Diseases
10. _ Tuberculosis
11. _ UTI in past 30 days
12. _ Viral Hepatitis
13. _ Wound Infection
14. _ Other: _____

c.) Neoplasms

_ If yes, specify type: _____

_____

d.) Endocrine/Nutritional/Metabolic Disease: (MDS Section I)

1. _ None
2. _ Diabetes Mellitus/Insipidus
3. _ Hyperthyroidism
4. _ Hypothyroidism
5. _ Obesity
6. _ Other: _____

e.) Immunity Disorders: (MDS Section I)

1. _ None
2. _ Cancer
3. _ Other: _____

f.) Blood Diseases: (MDS Section I)

1. _ None
2. _ Anemia
3. _ Other: _____

g.) Nervous System Disorders:

1. _None
2. _Transient Ischemic Attack (TIA)
3. _Cerebral Vascular Accident(CVA)
4. _ Aphasia
5. _Alzheimer's Disease
6. _Pick's Disease
7. _Multiple Sclerosis (MS)
8. _Parkinson's Disease
9. _Huntington's Disease
10. _Seizure Disorder
11. _ Dementia other than Alzheimer’s
12. _Traumatic Brain Injury
13. _Hemiplegia/Hemiparesis
14. _Paraplegia
15. _Quadraplegia
16. _Anoxia
17. _Other Nervous System Disorders: _____

h.) Heart/Circulatory System Diseases:

1. _ None
2. _ Arterioscleerotic Heart Disease
3. _ Cardiac Dysrhythmias
4. _ Congestive Heart Failure
5. _ Deep Vein Thrombosis
6. _ Hypertension
7. _ Hypotension
8. _ Peripheral Vascular Disease (e.g. Edema or Reyes Syndrome)
9. _ Other: _____

i.) Respiratory System Diseases:
1. _ None 2. _ Asthma
3. _ Emphysema 4. _ COPD
5. _ Other: _____

j.) _ Gastrointenstinal Disease
1. _ None

k.) _ Genitourinary Disease
1. _ None

l.) Dermatological Diseases:
1. _ None
2. _ Decubitus ulcers
3. _ Other: _____

m.) Musculo-Skeletal Diseases:
1. _ None 2. _ Fractures
3. _ Arthritis 4. _ Osteoporosis
5. _ Tardive Dyskinesia 6. _ Other: _____

n.) Congenital/Perinatal Disorders:
1. _ None
2. _ Cerebral Palsy
3. _ Mental Retardation/Developmental Disability
4. _ Other: _____

o.) Sensory Disorders:
1. _ None 2. _ Cataracts
3 _ Diabetic Retinopathy 4. _ Glaucoma
5. _ Macular Degeneration 6. _ Hearing Impairment
7. _ Other _____

p.) Other
1. _ None
2. _ Renal Failure
3. _ Allergies
4. _ Other _____

P H Y S I C A L E X A M I N A T I O N

37) Date of last complete physical exam found in record: __ / __ / ____

38) a) Computer Calculated Number of Days between last physical and Level II date: ____
b) Was Exam done within the last 90 days: ___ (Yes or No)

If date is beyond 90 days, an updated physical exam must be completed by an MD evaluator before evaluation is sent to DMH.

39) Vital Signs:
a. Blood Pressure: _____
b. Pulse Rate: ___
c. Respiratory Rate: __

40) Physical Appearance: _ (1 = good, 2 = fair, 3 = poor)

41) Systemic Examination:

	Finding	Source
a. HEENT	_	_
b. Skin	_	_
c. Chest/Heart	_	_
d. Respiratory	_	_
e. Gastrointestinal	_	_
f. Rectal	_	_
g. Genitourinary	_	_
h. Musculoskeletal	_	_
i. Lymphatic	_	_
j. Neurological:		
1. Cranial nerves	_	_
2. Sensory	_	_
3. Motor	_	_
4. Reflexes	_	_
5. Gait	_	_

Finding
1 = Normal
2 = Abnormal

Source
3 = Exam
4 = Record
5 = Refused

42) Physical Examination Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Skilled Nursing Procedures and Therapies

43) Skilled Nursing Procedures and Therapies Required:
(Check all that apply)

(MDS Section P)

	Y	Comments/Freq/Duration (Optional)
a. Physical restraints	__	_____
b. Posey restraints	__	_____
c. Oxygen therapy	__	_____
d. Ventilator/respirator	__	_____
e. Tracheostomy care	__	_____
f. Catheter/Ostomy care	__	_____
g. Dialysis	__	_____
h. Intake/Output	__	_____
i. Decubitus care	__	_____
j. Suctioning	__	_____
k. IV feeding/fluids	__	_____
l. Injections	__	_____
m. Tube feeding	__	_____
n. Special diet	__	_____
o. Meds admin/monitor	__	_____
p. Radiation	__	_____
q. Chemotherapy	__	_____
r. Maint acute med cond	__	_____
s. Pain management	__	_____
v. Other _____	__	_____

44) Rate care level 1-4 for Frequency:

	1-4	Comments
a. Bladder Incont. Care	___	_____
b. Bowel Incont. Care	___	_____

(MDS Section H)

45) Therapies:
(Check all that apply currently)

	Y	Comments/Freq/Duration (Optional)
a. Speech/Language	__	_____
b. Occupational Therapy	__	_____
c. Physical Therapy	__	_____
d. Alzheimer's or other Dementia Care	__	_____
e. Hospice Services	__	_____
f. Continence Retraining	__	_____
g. Vocational Therapy	__	_____
h. None	__	_____
i. Other _____	__	_____

(MDS Section P)

46) Physical health aids used or required: (MDS Sections C, D, L)
(check all that apply)

a. _ None
b. _ Eyeglasses
c. _ Hearing Aid
d. _ Dentures
e. _ Other: _____

47) Ambulation (Check all that apply) (MDS Section G and P)

a. _ Fully Independent
b. _ At risk for falls
c. _ Uses Cane or Walker
d. _ Walks Only with Assistance
e. _ Uses Wheel Chair Independently
f. _ Uses Wheel Chair/Must be pushed
g. _ Chairfast or Needs Posey Support
h. _ Bedfast
i. _ Transfers to toilet/bed from wheel chair
j. _ Resists using assistive devices
k. _ Other _____

C U R R E N T C O G N I T I V E S T A T U S

48) _Level of Consciousness:(enter 1 or 2) 1=Alert 2=Drowsy

49) Orientation: (Record resident's responses in full)

a. What is your full name? _____
_ Correct _ Incorrect

b. When were you born?_____ _ Correct _ Incorrect

c. Where are we now/What kind of place is this?_____
_ Correct _ Incorrect

d. Why do you think you are here? _____
_ Correct _ Incorrect

50) Immediate Verbal Recall/Learning:

a. Repeat these words: airplane, piano, orange.

b. Repeat all words until Resident has learned them all.

Trials to Criterion: ___

51) Attention: Repeat: 8-3-5-2-9-1 _____ _ Correct _ Incorrect

52) Construction:
a. Clock (provide a circle)
- Draw or point
- 10 minutes past eleven o'clock

53) Word Generation / Animal Test: (Provide the evaluator with instructions.)
a. Name as many animals as you can.
- Write the names
- Timed for 1 minute

54) Abstract Thinking:
a. A dog and a lion are alike in that they are both animals. How are a shovel and a rake alike?

_____
Response: Abstract:__ Concrete:__ Incorrect:__

b. How are pen and pencil alike?

_____
Response: Abstract:__ Concrete:__ Incorrect:__

55) Judgment:
a. Why shouldn't you yell "fire" in a crowded theatre?

_____
_ Correct _ Incorrect

b. What do you think is the right thing to do if you find you will be late for a doctor's appointment?

_____

56) Verbal Memory-Delayed Recall: Can you remember any of the words we practiced a little while ago?

Words	Response	Category Prompt	Response	Recognition (Check)		
Airplane	_____	Transportation	_____	_ Car	_ Violin	_ Red
Piano	_____	Musical Instrument	_____	_ Airplane	_ Guitar	_ Orange
Orange	_____	Color	_____	_ Boat	_ Piano	_ Yellow

# of words recalled _____ # recalled with prompt: _____ # of words recognized: _____

C U R R E N T M E N T A L S T A T U S

57) Appearance:
a. _ Unkempt b. _ Malodorous
c. _ Inappropriate/bizarre dress or makeup

58) Behavior:
a. _ Uncooperative b. _ Agitated(yells/screams)
c. _ Restless/hyperactive d. _ Distractible
e. _ Withdrawn f. _ Psychomotor retardation
g. _ Tics h. _ Bizarre/incongruent behaviors

For all items enter:

1 = None
2 = Mild
3 = Moderate
4 = Severe

59) Attitude:
a. _ Belligerent b. _ Dependent
c. _ Manipulative

60) Speech:
a. _ Selectively mute b. _ Slowed, low-toned
c. _ Circumstantial d. _ Pressure/rapid
e. _ Clanging/perverserate f. _ Incoherent

For 60.a: If 3 or 4 is entered, explain in item #74.

61) Thought Process:
a. _ Irrelevant b. _ Blocking
c. _ Flight of ideas d. _ Loose associations

62) Thought Content:
a.) Hallucinations:
1. _ command-type 2. _ visual
3. _ auditory 4. _ olfactory
5. _ tactile
b.) Delusions:
1. _ bizarre content 2. _ grandiose
3. _ persecutory 4. _ somatic
c.) _ Ideas of Reference
d.) _ Homicidal Ideation
e.) Suicidal Ideation/Risk
1. _ Plan 2. _ Thoughts
3. _ Other: _____

For all items enter:

1 = None
2 = Mild
3 = Moderate
4 = Severe

63) Affect/Mood: (observed) (reported/2 wks)
a. Angry ..... _ _
b. Flat/Blunted/feeling little/ no emotion ..... _ _
c. Inappropriate to content ..... _ _
d. Depressed/Sad/Hopeless ..... _ _
e. Anxious/Fearful/Feeling tense shaky ..... _ _
f. Elated/Expansive/Grandiose ..... _ _
g. Labile/Emotions change rapidly ... _ _
h. Other: _____ .... _ _

For all items enter:

1 = None
2 = Mild
3 = Moderate
4 = Severe

64) Neurovegetative Signs: (current) (reported/2 weeks)
a. Sleep (hypersomnia/insomnia) ..... _ _
b. Significant Appetite/Weight change ..... _ _
c. Other: _____ ... _ _

C U R R E N T P L A C E M E N T P O T E N T I A L

65) Personal care activities
a. _ Bathing
b. _ Dressing
c. _ Grooming
d. _ Eating
e. _ Using toilet

1 = Fully Independent
2 = Needs Reminders
3 = Needs Supervision
4 = Needs Physical Assist
5 = Needs Total Care

For numbers 66 and 67: If any item is rated at 4 (not able), provide an explanation in item #74

66) If placed in the community could the Individual:

Rating by evaluator	Source	Rating by individual	Other
a. _ Obtain food?	_	__	_____
b. _ Prepare meal?	_	__	_____
c. _ Obtain shelter?	_	__	_____
d. _ Clean residence?	_	__	_____
e. _ Obtain clothing?	_	__	_____
f. _ Do laundry?	_	__	_____
g. _ Take medication?	_	__	_____
h. _ Budget money?	_	__	_____
i. _ Keep clinical appt's?	_	__	_____
j. _ Seek medical assistance?	_	__	_____
k. _ Maintain employment?	_	__	_____
l. _ Use public transport?	_	__	_____
m. _ Community activities?	_	__	_____

(rating)
1=Independent
2=With supervision
3=With assist
4=Not able
5=Unable to rate

(source)
1=individual
2=conservator/family
3=record
4=staff
5=current assessment
6=other (who/what)

67) If placed in the community would the resident refrain from:

Rating	Source	Other
a. _ Using street drugs?	__.....	... _____
b. _ Abusing alcohol?	__.....	... _____
c. _ Wandering?	__.....	... _____
d. _ Trying to go AWOL?	__.....	... _____
e. _ Trying to hurt self?.....	__.....	... _____
f. _ Verbally assaulting others?..	__.....	... _____
g. _ Smoking in a hazardous manner?	__.....	... _____
h. _ Fire setting?.....	__.....	... _____
i. _ Damaging others' property?...	__..	_____
j. _ Physically hurting others?...	__..	_____
k. _ Stealing others' property?...	__..	_____
l. _ Engaging in sexual activities that violate the rights of others?.....	__..	_____
m. _ Disrobing in public?.....	__..	_____
n. _ Refusing medication?.....	__..	_____
o. _ Other: _____.....	__..	_____

(rating)
1=yes
2=with periodic monitoring
3=with ongoing treatment
4=not able
5=unable to rate

(source)
1=individual
2=conservator/family
3=record
4=staff
5=current assessment
6=other (who/what)
7=no information found

68) Individual Strengths (list positive traits and personal attributes):

_____

_____

69) Has the individual:
a. been free of placement problems in the community? _ Yes _ No _ Unknown
b. been treated in an STP Facility? _ Yes _ No _ Unknown
c. If yes, was the individual successful in the program? _ Yes _ No _ Unknown
d. If treated in STP but not successful, indicate year of prior STP admission and briefly describe why placement failed:
_____

70) Does the individual have friends or relatives to provide care in the community? _ Yes _ No _ Unknown

LEVEL II – PASRR

71) Individual wishes to: (select only one of the following)
a. _ Stay in current facility b. _ Transfer to another facility
c. _ Discharge to Board and Care d. _ Discharge to independent living
e. _ Discharge to Family
f. _ Other: _____

72) Discharge potential recorded on latest MDS: _

0=No discharge plans 1=Discharge within 30 days
2=Discharge within 31-90 days 3=Discharge status uncertain
4=Not available (MDS)

73) Enter discharge potential of individual: _ 1=Good 2=Fair 3=Poor

74) Additional Information/Clarification of Clinical Inconsistencies

_____
_____
_____
_____

D I A G N O S I S

75) DSM IV TR MULTIAXIAL CLASSIFICATION
a. Axis I. Primary: _____

Secondary: _____

Tertiary: _____

b. Axis II. Primary: _____

Secondary: _____

c. Axis III. Primary: _____

Secondary: _____

Tertiary: _____

d. Axis IV. Psychosocial/Environmental:

_____
_____
_____
_____

e. Axis V. Highest GAF Past Year:___ Current GAF:___

76) Differential Diagnosis: _____

_____

_____

_____

_____

LEVEL II – PASRR

R E C O M M E N D A T I O N S

77) Recommended level of care for individual's mental health status:

a. _ Acute psychiatric hospital

b. _ Psychiatric Health Facility (PHF)

If item "c" "d" or “e” is selected, provide M.H. Services data, and consider #78, below:

c. _ Special Treatment Program (STP)

----Mental Health Services-----	Recommended
1) None	_
2) Psychotropic medication education/monitoring	_
3) Independent medication management training	_
4) Individual psychotherapy	_
5) Group psychotherapy	_
6) Supportive Services	_
7) Family Therapy	_
8) Cognitive Behavioral Therapy	_
9) ADL training/reinforcement	_
10) Mental Health Rehabilitation activities	_
11) Substance Rehabilitation	_
12) Behavioral Modification program for: _____ _____	
13) Peer Counseling	_
14) Vocational Services	_
15) Educational Services	_
16) Other Recommended:_____ _____	

d. _ Skilled Nursing facility with mental health services to include, but not be limited to the following:

----Mental Health Services-----	Recommended
1) None	_
2) Psychotropic medication education/monitoring	_
3) Independent medication management training	_
4) Individual psychotherapy	_
5) Group psychotherapy	_
6) Supportive Services	_
7) Family Therapy	_
8) Cognitive Behavioral Therapy	_
9) ADL training/reinforcement	_
10) Mental Health Rehabilitation activities	_
11) Substance Rehabilitation	_
12) Behavioral Modification program for: _____ _____	
13) Day Treatment Intensive	_
14) Day Treatment Rehabilitation	_
15) Peer Counseling	_
16) Vocational Services	_

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17) Educational Services _
18) Other Recommended:_____
_____

e. _ Intermediate Care Facility with mental health services to include, but not be limited to the following:

----Mental Health Services-----	Recommended
1) None	_
2) Psychotropic medication education/monitoring	_
3) Independent medication management training	_
4) Individual psychotherapy	_
5) Group psychotherapy	_
6) Supportive Services	_
7) Family Therapy	_
8) Cognitive Behavioral Therapy	_
9) ADL training/reinforcement	_
10) Mental Health Rehabilitation activities	_
11) Substance Rehabilitation	_
12) Behavioral Modification program for: _____	
13) Day Treatment Intensive	_
14) Day Treatment Rehabilitation	_
15) Peer Counseling	_
16) Vocational Services	_
17) Educational Services	_
18) Other Recommended: _____	

If either item "f" or "g" is selected, provide M.H. services data below otherwise leave 1 thru15 blank

f. _ Residential Community Care Facilities

g. _ Board and Care or Other Community Placement: _____ with mental health services to include, but not be limited to the following:

----Mental Health Services-----	Recommended
1) None	_
2) Psychotropic medication education/monitoring	_
3) Individual psychotherapy	_
4) Group psychotherapy	_
5) Family Therapy	_
6) Cognitive Behavioral Therapy	_
7) Substance Rehabilitative services	_
8) Behavioral modification program for: _____	
9) Day Treatment Intensive	_
10) Day Treatment Rehabilitation	_
11) Consider referral for In-home Supportive Services (IHSS) Program:_____	_
12) Peer Counseling	_

13) Vocational Services _
14) Educational Services _
15) Other: _____

C O M M U N I T Y P L A C E M E N T A L T E R N A T I V E S

Most of the services have been described in terms used by the Medi-Cal Program. Under the Medi-Cal Program, there are eligibility, authorization and service limits that treating professionals must consider. For individuals who are not Medi-Cal eligible, private insurance and other resources should be explored for the delivery of similar services.

78) Assess potential for alternative placement(s) in the community for consideration by the treating professionals, when #77c Special Treatment Program (STP),#77d Skilled Nursing Facility (SNF)or #77e Intermediate Care Facility (ICF) Level of Care are recommended in item 77, above:

A. Placement Alternatives :
1) __ Private residence (home, apartment, supported housing, assisted living or public housing)
2) __ Group residence
a. _ Social Rehabilitation Facility
b. _ Adult Residential Facility
c. _ Residential Care Facility for the Elderly
3) Physically accessible features needed: _____
4) Other placements, comments, or conditions of note:
_____
_____

B. Community Support Services to Enhance Community Placements:
1) Specialty Mental Health Services
a. _ Residential Treatment
b. _ Day Treatment Intensive
c. _ Day Rehabilitation
d. _ Individual Mental Health Rehabilitation
e. _ Group Mental Health Rehabilitation
f. _ Targeted Case Management
g. _ Medication Support Services
h. _ Other services, comments, or conditions of note:_____
_____
_____
_____

2) Medical Health Services
a. _ Adult Day Health Care
b. _ Home Health Services
c. _ Durable Medical Equipment
d. _ Physical/Occupational/Speech Therapies
e. _ Other services, comments, or conditions of note:
_____
_____
_____
_____

3) Community Support Services
a. _ Adult/Older Adult Systems of Care

b. _ Peer Support/Self-Help Services
c. _ In-Home Supportive Services (IHSS) residual program
d. _ Personal Care Services Program (PCSP)
e. _ Program of All-Inclusive Care for the Elderly (PACE)
f. _ Adult Day Care
g. _ Home-delivered and Congregate Meals for the Elderly
h. _ Respite Care Services
i. _ Vocational Rehabilitation for Employment
j. _ Independent Living Center
k. _ Other services, comments, or conditions of note:

_____
_____
_____
_____

4) Home and Community-Based Waiver Programs [to address needs identified in items 24-47]: (For persons who meet Nursing Facility Level of Care)
a. _ AIDS Waiver
b. _ Multi-Purpose Senior Services Program Waiver
c. _ Nursing Facility Waiver A/B Waiver
d. _ Nursing Facility Subacute Waiver
e. _ In-Home Medical Care Waiver (hospital level of care)
f. _ Other services, comments, or conditions of note:

_____
_____

EVALUATION INFORMATION AND CERTIFICATION

79) a. Evaluation Start Time: __:__

b. Evaluation End Time : __:__

80) Level II Evaluator

a. Name: _____

b. Licensure: _____

c. Date: __/__/____

81) Physical History and Examination Certification by Medical Director

a. Name: _____

b. Licensure: _____

c. Date: __/__/____

82) Overall Certification by Quality Assurance Director

a. Name: _____

b. Licensure: _____

c. Date: __/__/____